Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael S. Perkins, MD

Respondent Name
Texas Association of Counties RMP

MFDR Tracking Number
M4-15-1629-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Lumbar Spine and Hip are considered two body parts. According to TDI/DWC and the AMA Guides 4th Edition the hip is considered part of the Lower Extremity and the Lumbar is considered the Spine."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position is that under DWC Rule 134.204(j)(4)(C), the examination in question was for the spine and pelvis and therefore did not involve an additional body area. Carrier therefore maintains its position as stated on the submitted EORs."

Response Submitted by: Parker & Associates, L.L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2014	Examination to Determine MMI/IR (99456 WP)	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 5049 – Rule §133.10(F)(U) Rendering provider's state license number (CMS-1500/Field 24J, shaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/Field 33; the billing provider shall enter the 'OB' qualifier and the license type, license number, and jurisdiction code
   - W3 – Additional payment made on appeal/reconsideration
   - 247 – A payment or denial has already been recommended for this service.

- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 18 – Duplicate claim/service.
- 306 – Billing is a duplicate of other services performed on same day.
- 193 – Original payment decision is being maintained. The claim was processed properly the first time.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet). (ii) The MAR for musculoskeletal body areas shall be as follows. (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."

   Review of the submitted documentation finds that the requestor performed a full physical evaluation with range of motion for the hip and an evaluation to determine the impairment rating of the lumbar using the DRE method found in the AMA Guides 4th edition to determine Impairment Rating. The AMA Guides 4th edition places the hips in the lower extremities (p. 79). Therefore, the correct MAR for these examinations is $450.00.
2. The total allowable for the disputed services is $800.00. Review of the submitted documentation finds that the insurance carrier paid $650.00. Therefore, additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	March 16, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.